

**Hull & ERY Children’s Neurodiversity Service**

**REQUEST FOR SUPPORT AND CONSENT FORM**

This service supports children and young people with neurodiverse needs (neurodevelopmental and neurodisability). A diagnosis is not required to access this service.

This service is for children and young people aged 0-18 years of age (and up to 25 with SEND) who are registered with a Hull or East Riding GP and living in Hull or East Riding.

A Request for Support can be made by parents and/or young people, and/or by staff who work to support them with parental consent. For parents/young people who contact the service in person or by telephone, the service can complete this form with you.

The completed Request for Support Form can be sent via:

* **Email:** Hnf-tr.herneurofrontdoor@nhs.net
* **Address: Hull & ERY Children’s Neurodiversity Service**,

 **2062-2068, Hessle Road, Hessle, HU13 9NW**

* **Telephone: 01482 692929**

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| If the child/young person’s concern is primarily related to mental health, call **Contact Point** **Telephone: 01482 303688.**  If the child/young person requires crisis support, call **the CAMHS Crisis Team. Telephone: 01482 301701 option 2.** |

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| 1. **CHILD/YOUNG PERSON & PARENTS DETAILS**
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| Child/Young Person FULL Name: |
| Parent(s) FULL Name(s): |
| Child/Young Person Address & Postcode:  |
| Child/Young Person’s Date of Birth: Age in Years: |
| NHS Number (if known): | Gender:

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| Male |  |
| Female |  |
| Non-Binary |  |
| Other |  |
| Prefer not to say |  |

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| Ethnicity: |
| Is English the parents/child/young person’s first language? Yes / No  |
| If no, what is the parents/child/young person’s preferred spoken language? |
| Is an interpreter or any alternative communication methods or aids required? Yes / NoIf yes, please state which:  |
| If you are a Parent, completing this form, do you have parental responsibility? Yes / No  |
| Does the child/young person/parent(s) live at the same address? Yes / No  |
| If No, state child/young person and/or parent(s) alternative address and contact details  |
| Is the parent /young person aware of this Request for Support? Yes / No  |
| Preferred method of communication (Please tick all that apply):1. Email 2. Text Message (SMS)
2. Telephone (Mobile/Home Telephone) 4. Post/Letter
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| Preferred communication contact details (email address, mobile telephone, home telephone) \*Please read and sign consent for use of mobile/telephone/email for contact purposes. (Section 12) |
| 1. **STAFF/PROFESSIONAL DETAILS**

**(If completing this form on behalf of a parent or young person)** |
| Staff/Professional Name & Job Title |
| Contact Details (Email, Address, Telephone) |
| Relationship to child/young person/family |
| 1. **HEALTH VISITOR / SCHOOL NURSE DETAILS**
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| HV / SN Name AddressEmailTelephone  |
| 1. **G.P DETAILS**
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| GP Name Address |
| Child/young person’s NHS Number (if known) |
| 1. **EARLY YEARS, SCHOOL, EDUCATION, TRAINING DETAILS**
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| **Please give details of the learning/education setting the child/young person attends from the list below.** |
| Early Years (e.g. Nursery/Childminder) |  |
| Mainstream School (Primary/Secondary) |  |
| Special school |  |
| PRU |  |
| College |  |
| Training |  |
| Work-based Training |  |
| Alternative provision |  |
| Educated at Home |  |
| Other (Please give details)  |  |
| Have any needs or concerns been identified by the learning/education setting which the child/young person attends?  | Yes / No  |
| If Yes, has the Parent/Young Person been informed what these are? | Yes / No |
| What is the child/young person’s preferred spoken language/alternative communication method? (please state)Is an Interpreter or any communication aids required? Yes / No If yes, please state |
| 1. **RISK to SELF or OTHERS**
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| Historic or current self-harm Yes / No  |
| Historic or current thoughts of suicide Yes / No |
| Any other risk Yes / No |
| **Please give details.** (e.g. Describe the incident, when, how often, any previous attempts/incidents).NB: If this form is being completed by a member of staff/professional it is the responsibility of the referrer to make a safeguarding referral if needed. |
| 1. **REQUEST FOR SUPPORT INFORMATION**
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| **Please describe the current concerns.** For example, Sleep, speech, language or communication, eating/drinking and/or swallowing, social communication and emotional, sensory (e.g. touch, smell, hearing and vision), early years/educational school support needs, behavioural/emotional concern, physical health concerns. **What is the main concern?**  |
| **How do these concerns impact on the child/young person daily life?**At home, nursery/school/college, social activities, family life. |
| **What do you hope will be achieved from this Request for Support?** **Describe which things are most important to you and/or the child/young person.** |
| **CONSENT, INFORMATION SHARING AND STORING INFORMATION** |
| 1. **PARENTAL /YOUNG PERSON CONSENT TO SHARE AND STORE INFORMATION**
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| I/The Parent/Young Person, consent to this Request for Support being made to the Hull & ERY Children’s Neurodiversity Service. I/The Parent/Young Person understand that this initial information provided, may need to be added to, and will be shared with a range of appropriate health, education and/or care and support services\* in order to identify a range of available support. This may lead to the identification of a Named Worker, who will be a key contact, provide support and help to coordinate other support that may be identified. If needed, the Service and/or the Named Worker contact the parent/young person for further discussion. This information will be shared and stored with a range of services/workers**\*** specific to my own/the child/young person’s needs **(\*See Section 9).** |
| Signature of the person giving consent |  |
| Name of the person giving consent |  |
| Telephone/Mobile Number  |  |
| Email address  |  |
| Date |  |
| 1. **STAFF/PROFESSIONAL CONFIRMING PARENTAL (YOUNG PERSON) CONSENT.**
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| For staff/professionals completing this form on behalf of the parent/young person, please confirm verbal consent been received to submit this request for support on their behalf? | Yes / NoDate verbal consent received: |
| Please ensure the parent/young person completes and signs the Consent Form (Section 7) and returns to the service. **Email:** Hnf-tr.herneurofrontdoor@nhs.net**Post:** Hull & ERY Children’s Neurodiversity Service, 2062-2068, Hessle Road, Hessle, HU13 9NW | Date Consent Form sent to Parent/Young Person by staff/professional.  |
| **10. \*SHARING OF INFORMATION OPT-OUT**  |
| **Please state any specific service(s) the parent/young person does not wish their information to be shared with.** This may reduce the availability of support for the child/young person and/or family.  |

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| **11. DETAILED CONSENT, INFORMATION SHARING AND STORAGE INFORMATION** |
| **Consent, Information Sharing and Storage**The parent/young person’s consent is required to enable health, education, care and support services/workers to review, discuss, share and store the information you provide in order to provide appropriate support.Requests for Support may be discussed by a multi-agency team in order to achieve the best outcome for the child/young person. This may include sharing and recording information provided and/or gathering information from health, education and care services the child/young person is or may be known to. This may lead to a range of support dependent upon the needs and outcomes identified, which occasionally may include different support provision to the areas that have been highlighted on this Request for Support form. The parent, child/young person will be involved and informed throughout. Relevant health, education, care and or support services will be informed of the outcome of the request.**Please read carefully:**The parent/young person. 1. Gives permission for this Request for Support to be reviewed by the Hull & ERY Children’s Neurodiversity Service which may include a number of staff from a range of children and young people’s services.

(For example, these could include any of the following services and support as appropriate: Health Visiting, School Nursing, GP, Early Years, Schools, Learning and Education providers, Sensory Processing, Autism, ADHD, Learning Disabilities, Therapy Services, voluntary and community sector services, Emotional Wellbeing and Mental Health including CAMHS, Acute and Community Paediatricians, Local Authority services).1. Has been informed of the purpose of this Request for Support and understands what that means:
2. Understands that a Request for Support does not guarantee that diagnostic assessments will be completed, but that they may be considered by an appropriate professional/service, dependent upon need and eligibility.
3. Agrees that the Service may seek and store information from other services (including medical and or other health, education, care and support services) who are, or may be, involved to assist with support/provision. AND will inform the Service of any other specific service/organisation they do not wish to be contacted/notified/involved, and what this may mean for the child/young person and /or parent.
4. Gives permission for the Service and their representatives to share/request relevant information and/or professional opinions about their child/young person with health, education, care and support staff/professionals/workers involved.
5. Understand they can withdraw their consent at any time by informing the Service by email/letter and/or by contacting the allocated Named Worker.
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| **12. PARENTAL/YOUNG PERSON CONSENT FORM** For communication via Text Messaging and/or Email  |
| When you are receiving a service from us, we want to keep in contact with you. We will do this in the way that is easiest or most convenient for you. We understand that people use email and mobile phone texts much more now. We also understand that you may want to let someone else receive or send messages for you. This could be someone who is looking after you or someone who you have chosen to help you.If you tell us that you would like to use email or mobile phone texts in this way, we will do this. First of all, we need to agree about how we do it and this is explained below. 1. We will use email or text messaging because you have told us this is how you want to keep in contact with us.
2. When sending messages outside of the NHS, there might be a risk of someone seeing the message who shouldn’t. To make it safer you should:
* Try not to use a public or work computer.
* Let us know immediately if you change your email address or mobile phone number.
* Do your best to keep the messages safe and confidential. For example, do not leave your computer switched on when you are not there and don’t tell somebody else your password.
* Have a pin code on your mobile phone and keep it secret.
1. Depending on the service you are receiving, it may be possible for you to send emails or texts to a Trust email address or mobile phone number. In such cases, you should
* Only send messages containing non-sensitive and non-urgent issues.
* Include your full name in the main part of an e-mail so that we can correctly identify you.
* Keep personal data sent in text messages to a minimum (your key worker will hold your contact details in an encrypted or pin coded mobile phone).
1. Your emails, text/voice messages to Trust mobile phones will be treated as non-urgent. We cannot say exactly when they will be actioned. If you need to contact us urgently you should telephone us on 01482 617758.
2. We will have to end this agreement if we find out that our systems are at risk from things such as computer viruses that are being sent.
3. When you send us a message, we will make a record of it in your notes.
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| **CONSENT**I accept the above conditions and agree for email/mobile phone texts *(delete whichever does not apply)* to be used to communicate with me and the Trust. **Confirm Email Address:** **Confirm Mobile Telephone Number:** ☐ Only tick this box if you prefer e-mails to be sent securely using the NHS encryption service. I understand I will need to register for this service electronically ☐ Only tick this box if you would like a copy of this form for your records If you give consent but would like to restrict the information that is shared using email/mobile phone texts (e.g. information about appointments only) please provide details below.**NAME:****SIGNATURE:****DATE:** |

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| **13. PRIVACY NOTICES** |
| **To see what we do with your data, please review the following Privacy Notices****Humber Teaching Foundation Trust** <https://www.humber.nhs.uk/about/privacy-notice-for-patients.htm>**City Health Care Partnership** <https://www.chcpcic.org.uk/pages/your-information-and-how-we-use-it>**Hull University Teaching Hospitals Trust**<https://www.hey.nhs.uk/privacy/>**East Riding of Yorkshire CCG**<https://www.eastridingofyorkshireccg.nhs.uk/publications/how-we-use-your-information-fair-processing-notice/>**NHS Hull CCG**<https://www.hullccg.nhs.uk/wp-content/uploads/2018/08/childrens-privacy-notice-poster-august-2018.pdf>**Hull City Council** <https://www.hull.gov.uk/help/privacy-notices/general-privacy-notice>**East Riding of Yorkshire Council**<https://www.eastriding.gov.uk/council/governance-and-spending/how-we-use-your-information/find-privacy-information/general-privacy-information/>**KIDS**https://www.kids.org.uk/kids-privacy-notice-cyp |

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| 1. **FOR OFFICE USE ONLY**

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| Date Request for Support received |  |
| Date Parent/Referrer notified of receipt of Request |  |
| Request: Type and Outcome |  |
| Date initial needs-led discussion. Key priorities/outcome(s) of that discussion.  |  |
| Information & advice, resources given. Local Offer details. | Yes / No |
| Parental support e.g. workshops/training opportunities identified.  | Yes / No  |
| Identified needs can be met without formal MDT Named Worker identified and agreed.  | Yes / No |
| Identified needs complex/require MDT Support | Yes / No |
| No Further Action and reasons why communicated to Parent and/or Referrer | Yes / No |
| Date of MDT (if applicable) |  |
| Outcome(s) of MDT. * *s*upport identified/agreed,
* progress to targeted/specialist services including additional assessment(s),
* expected outcome(s),
* Date of review MDT
 |  |
| Named Worker Details:* Name
* Job Title
* Service
* Email/ Telephone

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| Named Worker: Date of first contact with CYP/Parents   |  |
| Other relevant details  |  |